STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157645	A. BUILDING _____ B. WING _____	01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HOME HEALTH CARE LLC	7131 AIGNER CT INDIANAPOLIS, IN 46278

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G 000	INITIAL COMMENTS This visit was for a home health initial medicaid certification survey. This was a partial extended survey. Survey dates: 1/17-20/12 Facility # 012680 Survey Team: Dawn Snider, RN, PHNS Census Service Type: Skilled Patients: 18 Home Health Aide Only Patients: 0 Personal Service Only Patients: 1 Total: 19 Sample: RR w HV: 5 RR w/o HV: 5 Total RR: 10 Quality Review: Joyce Elder, MSN, BSN, RN February 2, 2012	G 000		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.	G 144		2/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	Continued From page 1 This STANDARD is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses coordinated the patient's care for 5 of 10 patient records reviewed (2, 3, 4, 5, and 7) with the potential to affect all the patients of the agency who received care from more than one service. Findings include: 1. Clinical record #2, start of care 11/23/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 2. Clinical record #3, start of care 11/21/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the occupational therapist. 3. Clinical record #4, start of care 11/4/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 4. Clinical record #5, start of care 12/9/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide, physical therapist, and occupational therapist. 5. Clinical record #7, start of care 10/24/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the therapist.	G 144		

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G 144	Continued From page 2 6. The undated policy titled "C-360 Coordination of Client Services" states, "1. Care conferences will be held as necessary to establish interchange, reporting and coordinated evaluation between all disciplines involved in the client's care. 4. Ongoing care conferences shall be conducted to evaluate the client's status and progress ... 6. Care conferences will be documented on the Care Conference Summary form or in the progress notes." 7. On 1/20/11 at 10:00 AM, the director of nursing indicated case conferences were conducted between disciplines but were not documented.	G 144		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on clinical record review, interview, and policy review, the agency failed to ensure a summary report had been sent to the physician at least every 60 days for 1 of 3 (1) records reviewed that had received services more than 60 days with the potential to affect all the patients of the agency. Findings include: 1. Clinical record #1, start of care 11/2/11, failed to evidence the registered nurse completed and sent a 60 day summary report to the physician. 2. On 1/20/2012 at 10:00 AM, the director of	G 145		2/15/12

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G 145	Continued From page 3 nursing indicated patient #1 had not had a 60 day summary sent to the physician. 3. The undated policy titled " C-645 Medical Supervision" states, "5. Written reports on the client's condition are provided to the physician at least every sixty days. 4. The undated policy titled " C-650 Physician Summary" states, "A summary report will be provided to the physician no less than every sixty (60) days."	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on clinical record and policy review and interview, the agency failed to visits and treatments were provided as ordered for 4 of 9 records with a written plan of care (3, 4, 5, and 6) and the potential to affect all the agency's patients. Findings include: 1. Clinical record # 3, start of care 11/21/11, included a plan of care for the certification period 11/21/11-1/19/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence skilled nurse visits the week of 11/25/11. 2. Clinical record #4, start of care 11/4/11,	G 158		2/15/12

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G 158	Continued From page 4	G 158		

included a plan of care for the certification period 11/4/11-1/2/12 with orders for home health aide 3 times a week for 8 weeks. Home health aide visits were made 5 times a week from 11/20/11 until 1/2/12.

On 1/20/12 at 4:20 PM, the administrator and the director of nursing indicated there were no orders for 5 times a week for certification period 11/4/11-1/2/12.

3. Clinical record # 5, start of care 12/9/11, included a plan of care for the certification period 12/9/11 - 2/6/12 with orders for skilled nurse visits 1 time a week for 3 weeks. The record failed to evidence the skilled nurse made visits on the week of 12/11/11 and made visits on both 12/21 and 12/22/11.

4. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period 11/18/2011-1/16/12 with orders for skilled nursing 1 time a week for 1 week then 3 times a week for 3 weeks. The record evidenced only 2 skilled nurse visits the week of 11/20/11, on 11/21 and 11/23/11.

A. The clinical record included labs results dated 11/30, 12/3, and 12/8/11. The plan of care failed to evidence an order for the labs.

1.) On 1/20/12 at 12:20 PM, employee M, the registered nurse, indicated she was monitoring the patient's PT/INR's with a coaguchek machine.

2.) On 1/20/12 at 12:40 PM, the administrator and the director of nursing indicated the plan of care did not contain orders for labs to be drawn

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G 158	Continued From page 5 on 11/30, 12/3, and 12/8/11. B. The plan of care included orders for a neurological assessment at each visit. The record failed to evidence a neurological assessment was completed on 11/21, 23, 28, and 30; 12/3, 8, 12, 16, and 12/23/11; and 1/6, 9 and 12/12. On 1/18/12 at 9:45 AM during the home visit, the director of nursing, who was making the skilled nurse, visit failed to do a neurological assessment. 5. The undated agency policy titled "B-360 Laboratory Testing" states, "Policy ... Testing done will be according to physician orders." 7. The undated agency policy titled "C-580 Plan of Care" states, "1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care services. 2. The Plan of Care shall be completed in full to include: ... l. Medications, treatments, and procedures. m. Medical supplies and equipment required."	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.	G 159		2/15/12

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G 159	Continued From page 6 This STANDARD is not met as evidenced by: Based on clinical record review, observation, interview, and policy review, the agency failed to ensure the plan of care was signed by the physician timely and included all the required elements in 7 of 9 (1, 2, 3, 4, 5, 6, and 8) clinical records reviewed with a plan of care and the potential to affect all the patients of the agency. Findings include:, 1. Clinical record #1 evidenced the physician signed the plan of care for the certification period of 11/2/11-12/31/11 on 1/17/12, over 30 days from the beginning of the certification period. 2. Clinical record #2 included a plan of care for the certification period of 11/23/11-1/21/12 that failed to include nutritional requirements, allergies, orders, and medications. 3. Clinical record #3 included a plan of care for the certification period of 11/21/11-1/19/12 that had not been signed by the physician. 4. Clinical record #4 included a plan of care for the certification period of 11/4/11-1/2/12 which the physician signed on 1/9/12, over 30 days from the beginning of the certification period. 5. Clinical record #5 included a plan of care for the certification period of 12/9/11-2/6/12 which the physician signed on 1/11/12, over 30 days from the beginning of the certification period. 6. Clinical record # 6 included a plan of care for the certification period 11/18/11 - 1/16/12 that	G 159		

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failed to evidence the patient had a wheelchair, walker, and glucometer; dressing supplies; and nitroglycerin medication.

On 1/18/12 at 9:45 AM, during the home visit, the patient was observed sitting in a wheelchair with a walker visible. The patient also indicated there were dressing supplies and nitroglycerin was taken for chest pain.

On 1/18/12 at 5:30 PM, the director of nursing indicated the patient had a glucometer to for self blood glucose monitoring.

7. Clinical record #8 included a plan of care for the certification period of 11/3/11-1/1/12 which was signed by the physician on 12/20/11, over 30 days from the beginning of the certification period.

8. The undated policy titled "Physician Signature Return Policy and Procedure" states, "If at day 25 the order has yet to be received with a signature, a member of Pure Home Health Care will hand deliver the order to physician's office to have the signature obtained."

9. The undated policy titled "C-635 All medications, treatments and services provided to clients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner.

10. The undated agency policy titled, "C-580 Plan of Care" states, "1. An individualized Plan of Care signed by a physician shall be required for each client receiving home health and personal care

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G 159	Continued From page 8 services. 2. The Plan of Care shall be completed in full to include: ... l. Medications, treatments, and procedures. m. Medical supplies and equipment required. ... 9. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care."	G 159		
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure skilled nursing services were provided in accordance with the plan of care on 3 of 8 (3, 5, and 6) records reviewed of patients with skilled nursing services with the potential to affect all the agency's patients who received skilled nursing services. Findings: 1. Clinical record # 3, start of care 11/21/11, included a plan of care for the certification period 11/21/11-1/19/12 with orders for skilled nurse visits 2 times a week for 9 weeks. The record failed to evidence skilled nurse visits the week of 11/25/11. 2. Clinical record # 5, start of care 12/9/11, included a plan of care for the certification period 12/9/11 - 2/6/12 with orders for skilled nurse visits 1 time a week for 3 weeks. The record failed to evidence the skilled nurse made visits on the week of 12/11/11 and made visits on both 12/21 and 12/22/11.	G 170		2/15/12

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G 170	Continued From page 9 3. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period 11/18/2011-1/16/12 with orders for skilled nursing 1 time a week for 1 week then 3 times a week for 3 weeks. The record evidenced only 2 skilled nurse visits the week of 11/20/11, on 11/21 and 11/23/11. A. The clinical record included labs results dated 11/30, 12/3, and 12/8/11. The plan of care failed to evidence an order for the labs. 1.) On 1/20/12 at 12:20 PM, employee M, the registered nurse, indicated she was monitoring the patient's PT/INR's with a coaguchek machine. 2.) On 1/20/12 at 12:40 PM, the administrator and the director of nursing indicated the plan of care did not contain orders for labs to be drawn on 11/30, 12/3, and 12/8/11. B. The plan of care included orders for a neurological assessment at each visit. The record failed to evidence a neurological assessment was completed on 11/21, 23, 28, and 30; 12/3, 8, 12, 16, and 12/23/11; and 1/6, 9 and 12/12. On 1/18/12 at 9:45 AM during the home visit, the director of nursing, who was making the skilled nurse, visit failed to do a neurological assessment.	G 170		
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions.	G 173		2/15/12

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G 173	Continued From page 10 This STANDARD is not met as evidenced by: Based on clinical record and policy review, the agency failed to ensure the registered nurse specified the information on the plan of care in 3 of 9 clinical records reviewed with a plan of care (1, 2, and 6) with the potential to affect all of the agency's patients. Findings include: 1. Clinical record #1, start of care 11/2/11, included a plan of care for the certification period 1/1/12-2/29/12 that failed to evidence when to notify the physician for pain level. The plan of care states, "SN to report to physician if patient experiences pain level not acceptable to patient, pain level greater than __ (this was left blank), pain medications not effective, ..." 2. Clinical record #2, start of care 11/23/11, included a plan of care for the certification period 11/23/11 -1/21/12, failed to evidence what the skilled nurse and the home health aide were supposed to do. 3. Clinical record #6, start of care 11/18/11, included a plan of care for the certification period of 11/18/11-1/16/12 that failed to evidence specific orders for the wound care and amount of insulin to be provided. The plan of care states, "SN [skilled nurse] to clean wound, ulcer with Normal Saline, pat dry, apply_____ (this was left blank), pack with sterile ..." The plan of care further states, "SN to prep/administer, _____ ____ (these were left blank), units QAM SQ and _____ _____ (these were left blank), units QPM [ever night]. ...	G 173		

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G 173	Continued From page 11 Sn [skilled nurse] to prep [prepare] /admin [administer] _____ (this was left blank) per sliding scale. 4. The undated agency policy titled, "C-200 Skilled Nursing Services" states, "1. The registered nurse: ... c. Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan."	G 173		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on clinical record and agency policy review and interview, the agency failed to ensure the registered nurses coordinated the patient's care for 5 of 10 patient records reviewed (2, 3, 4, 5, and 7) with the potential to affect all the patients of the agency who received care from more than one service. Findings include: 1. Clinical record #2, start of care 11/23/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 2. Clinical record #3, start of care 11/21/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the occupational therapist.	G 176		2/15/12

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G 176	Continued From page 12 3. Clinical record #4, start of care 11/4/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide. 4. Clinical record #5, start of care 12/9/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the home health aide, physical therapist, and occupational therapist. 5. Clinical record #7, start of care 10/24/11, failed to evidence any documentation the registered nurse coordinated the patient's care with the therapist. 6. The undated policy titled "C-360 Coordination of Client Services" states, "1. Care conferences will be held as necessary to establish interchange, reporting and coordinated evaluation between all disciplines involved in the client's care. 4. Ongoing care conferences shall be conducted to evaluate the client's status and progress ... 6. Care conferences will be documented on the Care Conference Summary form or in the progress notes." 7. On 1/20/11 at 10:00 AM, the director of nursing indicated case conferences were conducted between disciplines but were not documented.	G 176		